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VOLUME 8, NUMBER 7 OCTOBER 15, 1950

ANN WILSON HAYNES, Editor
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Today we are hearing much about the beneficial effects of adding fluorides to water in reducing tooth decay. Some communities in other sections of the Country have added fluorides to their domestic water supplies and the projects are being carefully watched with scientific interest. Several communities in California are considering such a program.

This article on the Riverside County study shows us another aspect of the fluoride picture—where an excessive amount of fluorides in the drinking water causes "fluorosis," or mottling of tooth enamel. Analyses of 43 wells in the Oasis area of Riverside County disclosed fluoride concentrations ranging from 0.06 to 11.0 parts per million. (One part per million is considered optimal for the effective reduction of dental caries; concentrations above that amount favor mottling.) The survey found that 67 children, or 42 percent, out of 158 examined at Oasis School had mottling in various degrees of severity.

Thus study was not intended to correlate statistically dental decay or mottling with concentrations of fluoride, but was conducted primarily to "survey" the extent of an existing and recognized condition as a preliminary step toward finding a way to reduce the excessive concentrations, or in other ways to control the individual intake of fluorides and thus control fluorosis.

Fluorosis Survey in Riverside County

LAURENCE S. MCCLASKEY, D.D.S., M.P.H., E. TAYLOR DYKES, D.D.S., and ARLENE LEWIS, Public Health Analyst, Division of Dental Health

Considerable interest has been focused on the chemical element fluorine and its relationship to dental health. For the past 20 years attention has been directed toward developing the possible use of fluorides as a means of reducing dental decay.

Excessive Fluorides Cause Mottling

A dental condition termed "mottled enamel" brought about the discovery of fluorides in water supplies. This dental condition is clinically evidenced by a discoloration of chalky white, yellowish brown, or blackish stains, and possible later disintegration of the enamel. Investigation revealed that the condition existed in many areas in the United States and in other countries as well. Further study disclosed that people who drank water from the same source from birth to 10 years of age had mottled enamel, while adults coming into the areas did not develop this condition. Studies were made of the water supplies of these areas and, in 1931, it was discovered that the mottled enamel was caused by the presence of an excessive amount of fluorides in the drinking water. The term "dental fluorosis" has since been applied to the condition popularly known as "mottled enamel."

Before the cause of mottled enamel was discovered, studies revealed that the incidence of dental caries was lower in those places where mottling occurred than in areas where there was no mottling. Carious teeth were comparatively few even when the enamel was defective.

Beneficial Effects of Fluorides Noted

Knowing that too much fluoride in drinking water was not desirable but that the presence of some fluoride resulted in less caries, the United States Public Health Service set about to determine the concentration to which fluorides should be reduced to avoid mottling. The findings of their studies showed that the optimal amount should be approximately 1.0 part per million. These studies also established that an effective reduction of caries would result from this same 1.0 part per million concentration of fluorides. Communities in several states are now adding fluorides to their water supplies. Several communities in California are considering such a program. Extensive research has also shown

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that the application of sodium fluoride to the exposed crowns of the teeth of children (at about the ages of 3, 7, 10 and 13 years) may result in a 40 percent reduction in new decayed tooth surfaces.

Fluoride concentrations in excess of one part per million are reported for several areas in California. Concentrations for some areas have been reported as high as 20.0 parts per million. Dental fluorosis exists in many of these areas but the extent or severity has never been determined. Early this year an opportunity for a study of this condition became possible.

The Riverside Problem

Residents of Oasis, in Riverside County, were greatly concerned about the mottled teeth of their children. They knew that many of the wells in the area contained excessive amounts of fluorides and that the school well had been reported to have concentrations varying from 2.5 to 13.0 parts per million. The Oasis Parent-Teacher Association wrote to the Riverside County Health Officer requesting information on the effects of too much fluoride in the drinking water and possible methods for removing or reducing the fluoride. This letter was referred to the Division of Dental Health of the State Department of Public Health.

In order to determine the extent of dental fluorosis and to make recommendations for the alleviation of this condition, the Division of Dental Health made arrangements to conduct a survey. School children would be examined to measure the proportion of students affected and to determine the severity of the fluorosis. This survey would be conducted at Oasis and also at Thermal, 10 miles from Oasis, upon the request of the principal. The division staff was assisted in arranging for the survey by the principals of both schools. Preliminary to the survey, statistical record forms were made available to the two schools. On these forms the teachers supplied identifying information for each student, such as name, age, sex, and race, as well as additional information on address, place of birth, and years in the area.

Oasis Survey

During the last week in May a team of two dentists and a public health analyst from the division went to the Oasis Elementary School. A state dental trailer was used to facilitate the examinations. The dentists examined each student, using mouth mirror, explorer and a good light, and called code descriptions for each tooth surface. Data recorded indicated the condition of the tooth, whether sound, carious, filled, mottled, etc., and distinguished between deciduous and permanent teeth. Bite-wing X-rays were taken of children in the upper grades. Kodachrome transparencies were taken of teeth showing fluorosis.

Findings

At the Oasis School 158 pupils were examined, including kindergarten through the eighth grade. Fluorosis was evident in varying degrees of severity in 67 of the children (42 percent). Of these, 34 had lived in the area since birth. Approximately half of the pupils required dental care; for these pupils mimeographed slips were completed, suggesting they report to their family dentist for further examination and diagnosis. The slips were signed by the principal and sent to the parents.

At the Thermal School 357 pupils were examined, including kindergarten through the eighth grade. Only 33 pupils, less than 10 percent, showed evidence of fluorosis. Slightly less than 40 percent of the pupils needed dental care. For those pupils mimeographed slips were sent to the parents. Further statistical detail was not practical for the small number of children examined at each school.

At the time of the survey, it was assumed that a high fluoride concentration was present in the water supplies at Oasis and a negligible amount present at Thermal. The examination results are substantiating but reveal more fluorosis at Thermal than was expected. Without information on the actual fluoride concentration, comparisons between the schools are limited.

Because of the wide variation of the fluoride content in the many wells in Oasis and vicinity, it was necessary to arrange for a new water analysis of each well. To date, analyses of 43 wells disclosed fluoride concentrations ranging from 0.06 to 11.0 parts per million. Seventy-four wells remain to be analyzed. This work is being done as a project of the Riverside County Health Department.

At the present time the Division of Dental Health, in cooperation with the Riverside County Health Department, is investigating various methods for removing excess fluorides from the drinking water.

References

1. Pelton and Weisan, *Dentistry in Public Health*, Saunders, N. Y., Jan. 1949, pp. 136-7.
2. "Fluorine and Good Teeth," Ozark-Mahoning Company, *Information Circular No. 1*, Tulsa, Okla., Mar. 1950.

Board Members Reappointed

Dr. Charles E. Smith, University of California School of Public Health, and Dr. James F. Rinehart, University of California Medical School, San Francisco, have been reappointed by Governor Warren to serve new four-year terms on the State Board of Public Health. The appointments were made September 13th. Doctor Smith has served as president of the board since April 1945. Doctor Rinehart has served as the board's vice president.

There are many techniques which may be used in establishing the status of dental health in a community. The technique used in the Santa Barbara survey is considered a practical and rapid method of finding gross dental defects and of compiling base-line data for the planning of a community dental health program.

The Santa Barbara survey included 6,878 children. One out of four (23 percent) were found to be in need of treatment and were referred to their family dentists. From the survey data it was estimated that the average number of carious permanent teeth per child in Santa Barbara County schools varies from 0.1 to 2.0.

In subsequent issues of California's Health other surveys, using different techniques, will be reported and the findings compared.

Santa Barbara County Surveys Dental Status of Elementary School Children

I. O. CHURCH, M.D., Health Officer, R. A. KING, D.D.S., Public Health Dentist, and ELEANOR LANGPAAP, Public Health Analyst, Santa Barbara County Health Department

A dental survey to provide the Santa Barbara County Health Department with information relative to existing dental conditions of elementary school children was completed during 1949. This survey will provide base-line data to aid in planning a dental program for Santa Barbara County and in measuring the progress of that program.

Preliminary Decisions

In planning the survey several decisions on procedure were made. Existing dental records were examined and considered inadequate for evaluating former dental services to the community. Detailed dental examinations on a mass survey basis were considered impracticable because of the amount of time needed to gather all the information, the need for additional personnel to make examinations, and the time and effort needed to tabulate and analyze all the examination records. Furthermore, it was decided that the survey should be completed in a relatively short period of time in order to maintain statistically comparable data from one area to another.

The simplified method [1] selected for appraising the dental health program, and described herein, is based on the relationship which exists between the proportion of children who exhibit at least one decayed, missing, or filled permanent tooth (DMF) and the average number of DMF teeth per child.[2] This relationship allows an estimate to be made of the prevalence of dental caries per child by age.

One of the values of the promotion of dental examinations and treatment is to prevent tooth loss. A reduction in tooth mortality is objective evidence of the value of a dental program. The survey method adopted had the advantages of simplicity and rapidity in the collection and tabulation of data basic to a dental program. It provided actual evidence of the proportion of school children who have filled deciduous and filled permanent teeth.

Survey Area

The area served by the Santa Barbara County Health Department comprises about 2,400 square miles, four-fifths of the area being mountainous. The largest city located in the northern part of this area is Santa Maria with an estimated population of 10,094. The remainder of the county is predominantly rural except for Santa Barbara City, which is located in the southern end of the county and is served by its own city health department. The total estimated population (1949) for the Santa Barbara County Health Department jurisdiction was 50,900. There are 65 dentists throughout the county, 53 of whom practice in the City of Santa Barbara.

Forty schools with elementary grades, two of them parochial, were included in this study. All children from the kindergarten through the eighth grades were inspected. Children attending some of the county elementary schools located near the city of Santa Barbara enroll in the city secondary schools which are under the jurisdiction of the city health department. Because of this fact, the secondary schools in the county area were not included in this survey since the sample of those age classes would not be complete. The range of enrollments in the county elementary schools varies from 8 to 865 students. This survey included 6,878 children.

Survey Technique

The technique of conducting the DMF survey was patterned after the one used in Nicollet County, Minnesota, in 1946. The dentist made the inspections with the aid of a tongue blade and strong light and the dental assistant recorded the answers to the required information listed as follows:

(1) Does the child have at least one decayed, missing, or filled permanent tooth?
(2) Does the child have at least one filled deciduous tooth?

(3) Does the child have at least one filled permanent tooth?
(4) Record the number of extracted permanent teeth and specify the locations.
(5) Record the number of permanent teeth indicated for extraction and specify the location.

Excellent cooperation of school administrators and teachers made it possible for the survey to proceed without a hitch. They made ready all preliminary data (names, ages, sex and races of children to be inspected). As each inspection was finished, the child was given a mimeographed form to take home to his parents which explained the fact that this survey was not a *complete* examination, but one to record only the obviously decayed, missing, and filled permanent teeth. Parents were urged to keep their child under the care of their family dentist.

If the examiner observed that a child was in need of immediate dental care, a note was sent home to the parents urging them to consult their family dentist as soon as possible. Because of the simplicity in the manner of recording this survey information, a cross-mark was placed after the name of every child who was referred to his private dentist for immediate care, and a tabulation was made of this supplementary information.

The survey was completed in 15 days. Tabulations and analyses were finished in an additional two weeks.

Analysis

Table 1 presents a summary of the DMF survey. (A comparison between the Nicollet County, Minnesota, survey in 1946 and the recent Santa Barbara County Health Department survey was also made but full statistical details of this comparison are not included here. Justification for the comparison was based on the fact that purposes for conducting the survey and the procedure for carrying out the inspections were similar.)

The tooth-mortality rates in Santa Barbara County are slightly higher in the 9-, 10-, 11- and 13-year-age classes than those of Nicollet County, with the greatest relative difference occurring in the nine-year-old group. In the over-all picture, the rates are quite similar. It is well to remember at this point that the 1946 Nicollet County survey was done to determine the status of dental conditions in school children after a program to improve dental health had been operating for over five years, and it showed that there had been about a 30 percent over-all reduction in tooth-loss among the children of that county since the inception of the program in 1940.

In all other dental conditions, there is a marked difference between the two counties. In an over-all picture, the comparison between the Santa Barbara County and Nicollet County dental surveys reveals the following:

(1) The proportion of school children in Santa Barbara County exhibiting at least one decayed, missing, or filled (DMF) permanent tooth is approximately 30 percent lower than that of Nicollet County. This difference may be a real one with respect to a lower caries attack rate, and it may also be a reflection to some degree of the personal technique of the examiner.
(2) The proportion of children with at least one filled permanent tooth is about 39 percent lower than that of Nicollet County school children.
(3) The proportion of children who have at least one filled deciduous tooth is about 13 percent lower than that of Nicollet County children.

TABLE 1

Summary of the Prevalence of Certain Dental Conditions Among 6,878 County School Children[1] by Age
Santa Barbara County Health Department—1949

	Age at Last Birthday (in years)														
	4	5	6	7	8	9	10	11	12	13	14	15	16	17	Unk'n.
Number of children	197	731	893	854	747	737	747	633	568	510	166	39	7	1	48
Children with at least one DMF[2] permanent tooth															
(1) Number	0	5	32	131	201	299	401	381	368	349	117	30	3	1	8
(2) Percent	0.0	0.7	3.6	15.3	26.9	40.6	53.7	60.2	64.8	68.4	70.5	–	–	–	–
Missing[3] permanent teeth															
(1) Number	0	0	1	3	10	37	50	59	74	129	41	15	0	2	2
(2) Number per child	.000	.000	.001	.004	.013	.051	.068	.093	.131	.253	.247	–	–	–	–
Children with at least one filled perm. tooth															
(1) Number	0	3	15	67	133	207	265	259	258	259	73	18	1	0	4
(2) Percent	0.0	0.4	1.7	7.8	17.8	28.1	35.6	40.9	45.4	50.8	43.9	–	–	–	–
Children with at least one filled decid. tooth															
(1) Number	33	154	219	267	259	287	214	126	38	16	1	0	0	0	8
(2) Percent	16.8	21.1	24.5	31.3	34.7	38.9	28.6	19.9	6.7	3.2	0.6	–	–	–	–
Children referred for dental care															
(1) Number	40	170	238	248	250	185	145	111	85	64	35	9	1	1	14
(2) Percent	20.3	23.3	26.7	29.0	33.5	25.1	19.4	17.5	14.9	12.5	21.1	–	–	–	–

[1] Elementary grades, kindergarten through eighth grade. [2] Decayed, missing, filled. [3] Extracted and teeth indicated for extraction.
– Not calculated for age classes with less than 100 children.

Table 1 includes supplementary information on the proportion of children referred to their family dentist for treatment. These referrals were based on (1) the presence of at least one perceptible and diagnosible carious tooth which was restorable, or (2) the presence of a tooth which was indicated for extraction because of gross infection.

An over-all average of 23 percent of the school children were referred to their family dentists, but when reviewing the individual age groups it is noted that even in the four-year-old group about 20 percent of the children were in need of treatment. The proportion increases to 34 percent of the eight-year-old group who were referred for care. This indicates that a considerable number of the younger school children need dental care and that this need was based only on the quick recognition of gross dental defects. It was evident that as the proportions of filled deciduous and filled permanent teeth decrease, the percent of children referred for dental treatment increases.

To compare the results of each school separately would introduce large sampling errors. About one-half of the schools have attendances of less than 100 pupils and percentages or rates based on such small numbers would be statistically unreliable. In addition, the DMF survey is not intended to give detailed information for each child or for each school included in the survey, but rather is an estimate of the gross dental conditions. If more exact methods of examination were used, such as X-ray, explorer and mirror, there is no doubt that the proportion of children exhibiting carious permanent teeth would be higher.

In order to determine to some degree the regional differences in the prevalence of certain dental conditions, the schools were grouped according to public health nursing districts. (A breakdown of this data has not been included here.)

It is estimated (Table 2) that over the age-interval of 6 years to 14 years, the average number of carious (DMF) permanent teeth per child varies from 0.1 to 2.0 in the county school children. These values are derived from a graph designed for estimating the average number of DMF permanent teeth per child from the determined proportion of children exhibiting evidence of at least one such carious tooth.[2] The range of carious permanent teeth per child for these age groups is lower than those observed in other dental surveys.[2]

TABLE 2

Estimate * of the Number of Carious (DMF) Permanent Teeth per Child by Age Groups for County School Children Santa Barbara County, 1949

Age last birthday (years)	Number of children	Number with at least one DMF permanent tooth	Percent with at least one DMF permanent tooth	Estimate of the number of DMF permanent teeth per child
4	197	–	–	0.0
5	731	5	0.7	0.0
6	893	32	3.6	0.1
7	854	131	15.3	0.3
8	747	201	26.9	0.5
9	737	299	40.6	0.9
10	747	401	53.7	1.3
11	633	381	60.2	1.5
12	568	368	64.8	1.7
13	510	349	68.4	1.9
14	166	117	70.5	2.0
15	39	30	76.9	–
16	7	3	42.9	–
17	1	1	100.0	–
Unknown	48	8	16.7	–
Total	6,878	2,326	33.8	

* Estimated from graph of catalytic curve showing correlation between percentage of children with one or more (DMF) carious permanent teeth and average number of (DMF) carious permanent teeth per child. John W. Knutsen, Dental Surgeon, USPHS, "Index of the Prevalence of Dental Caries in School Children." (2)
– Not estimated for age classes with a total less than 100 children.

References

[1] John W. Knutson, Cecelia Maday, and William A. Jordan: *Simplified Appraisal of Dental-Health Programs.* Public Health Reports, Vol. 62, No. 12, March 21, 1947.

[2] John W. Knutson: *An Index of the Prevalence of Dental Caries in School Children.* Public Health Reports, Vol. 59, No. 8, February 25, 1944.

State, Territorial Health Officers

Public health officials from all the states and territories and from the provinces of Canada will meet October 23-27 at one of the largest gatherings of public health administrators ever held in Washington. Dr. Wilton L. Halverson, California Director of Public Health, is president of the Association of State and Territorial Health Officers.

The meeting coincides with the 49th annual conference of administrators of state health programs called by Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, and will deal chiefly with the health and medical aspects of civil defense planning. The program will also include two days of scientific sessions at the National Institutes of Health, the Public Health Service's research center at Bethesda, Maryland.

Engineer Positions

Santa Clara County—Dr. W. Elwyn Turner, Santa Clara County Health Officer, announces a position for a chemical engineer to work on air pollution and industrial sanitation in the Division of Sanitation. A degree in chemical engineering is desired, but no experience is required. For further information contact Dr. Turner.

San Diego City and County—An examination for the position of public health engineer has been announced by Dr. J. B. Askew, San Diego City and County Health Officer, with the date to be set later. Applicants must file by October 24th. The position will be Chief of the Division of Sanitary Engineering, with a starting salary of $507. Applicants must have a degree in either civil or sanitary engineering.

Joint School Health Committee States Policy on Program Responsibility

A new policy statement on the responsibilities of public schools and health departments in the development of the school health program has been issued by the State Joint Committee on School Health. A revision of an earlier document, the new statement, which has been approved by the directors of the State Departments of Education and Public Health, now becomes the official policy of the two departments.

It is hoped that the statement will be helpful to local public health and school departments in planning for more effective school health services. The State Joint Committee is composed of members of staffs of the State Department of Education and the State Department of Public Health. The statement follows:

Joint Committee Statement

Both school and health departments have great interest in, and important contributions to make to the development and improvement of health programs for children of school age. The schools have intimate knowledge of the children as a result of daily contact and observation and an understanding of the part health service plays in the total educational experience of each child. Health departments have knowledge of the health problems and resources of the community as they affect children of all ages and their families. Both departments have personnel whose skills are needed in solving school health problems.

The responsibility for providing school health service varies in states and in communities for a number of reasons. In some areas, particularly in cities, schools have taken leadership; in others health departments have taken leadership. It is becoming increasingly apparent that the degree of mutual understanding which exists between the two agencies, with the resultant pooling of resources of both departments, is far more important than which department provides the medical and nursing service. Any misunderstandings which may have retarded effective functioning of school health programs can be dissipated by the acceptance of a school health program based on cooperation and joint planning.

State Laws Nurture Cooperation

In California, under provisions of the Education Code and the Health and Safety Code, both school and health departments have certain responsibilities for the health of children attending school. This is fortunate. No legal obstacles prevent cooperation between the two departments. The law actually makes cooperation necessary.

Practically every authoritative statement concerning school health issued in recent years has emphasized this principle of cooperation. The revised *School Health Policies* report sponsored by the National Conference for Cooperation in Health Education states:

> Every school system under whatever jurisdiction it operates, should have a Central Health Council or committee with appropriate representation from all schools and from all groups interested in school health. At the level of the Central Health Council, where, for example, the city or county superintendent of schools and the city or county health officer meet, the fruitfully cooperative relationships between the school system and the health department can best be worked out.

In another report recently issued by the same conference, the responsibility of the school administrator, physician and nurse in the school health program is stated as follows:

> The technique of thinking together, working together, and planning together to develop the best plan for united action in a given program, with each participant understanding his responsibilities in relation to the work of others can be used successfully in solving school health problems throughout the Country.

In a recent survey it was found that 27 states now have formal plans for interdepartmental cooperation with respect to school health programs. At the federal level there has been cooperative planning for school health between the Public Health Service, the Children's Bureau, and the Office of Education.

State-level Planning

In California the Joint Committee on School Health, composed of representatives of the staffs of the State Department of Education and the State Department of Public Health, has made significant progress toward the establishment of cooperative planning at the state level. All publications dealing with health in the schools are considered by the committee and are released under the auspices of both departments. Functions of the two departments concerning nutrition and school lunch programs, special programs for handicapped children, school health records, the curriculum in health, in-service and preservice training of school and health department personnel, and in many other areas there has been correlation through the medium of the joint committee. The work of the committee serves as an outstanding example of joint planning and cooperation for the best interests of the children of the State.

It is the hope of the two state departments that similar joint committees representing school and public health departments will be developed and strengthened in local communities. As persons come to understand

each other better by working on mutual problems, the contributions which each department makes to the health of the school child will be improved.

Approved: ROY E. SIMPSON, Director
State Department of Education
WILTON L. HALVERSON, M.D., Director
State Department of Public Health

State Plan Evolving for Emergency Health and Medical Services

Groundwork for a state plan which will marshal health and medical resources of California for readiness in time of emergency is rapidly taking shape. Recommendations for the state plan have been drafted by the Citizens Advisory Committee, appointed by Governor Warren in July, and serving under the direction of Dr. Wilton L. Halverson, California Director of Public Health.

The plan for medical and public health services will become a part of the over-all State Plan for Civil Defense as provided for in the California Disaster Act. Governor Warren has appointed Dr. Halverson Director of Medical and Public Health Services in the Civil Defense organization.

Members of the Advisory Committee, representing 25 organizations concerned with medical and public health services in the State, were announced in the July 31st issue of *California's Health*. Justin J. Stein, M.D., Los Angeles, is serving as chairman, with George M. Uhl, M.D., Los Angeles as vice chairman. Since that time several new members have been added as follows:

J. B. Askew, M.D., San Diego County Health Officer, representing the California Conference of Local Health Officers.
Ben H. Dean, D.V.M., Berkeley, California State Veterinary Medical Association.
Mr. Richard Hopelain, San Francisco, Northern California Pharmaceutical Association.
Mr. Oscar McCracken, Los Angeles, California Pharmaceutical Association.
W. Ballentine Henley, D.O., College of Osteopathic Physicians and Surgeons.
Wilmot F. Robinson, D.O., California State Association of Osteopathic Physicians and Surgeons.

Five subcommittees, established for analysis of specific problems have been serving as follows:

1. *Medical and Related Personnel and Training*

Col. M. T. Kubin, M.C., U.S.A., San Francisco
Earl R. Miller, M.D., San Francisco
J. P. Owen, M.D., San Francisco
Harold Pearson, M.D., Los Angeles
Edward S. Rogers, M.D., Berkeley
George M. Uhl, M.D., Los Angeles
Elwood Wait, D.D.S., San Francisco
Wilma York, R.N., San Rafael

2. *Medical Facilities and Supplies*

Mr. A. A. Aita, Upland
Rodney Beard, M.D., San Francisco
A. F. Brand, M.D., San Francisco
Comdr. Chester S. Fay (MSC) USN, San Francisco
Col. Paul C. Gilliland (MC) USAF, Hamilton Air Force Base
Mr. Richard Hopelain, San Francisco
Mr. R. B. McClellan, Lompoc
Mr. Oscar McCracken, Los Angeles
J. P. Owen, M.D., San Francisco

3. *Public Health Services*

J. B. Askew, M.D., San Diego
A. F. Brand, M.D., San Francisco
Mr. Lawrence Cook, Menlo Park
Mr. John S. Longwell, Piedmont
Walter McPherson, M.D., Los Angeles
George M. Uhl, M.D., Los Angeles

4. *Mortuary Services and Vital Records*

Mr. Jay Jensen, Colma
Mr. Lloyd H. Truman, Oakland

5. *Public Information and Education*

Mr. A. A. Aita, Upland
J. B. Askew, M.D., San Diego
J. P. Owen, M.D., San Francisco
Mr. Lloyd H. Truman, Oakland

Each subcommittee has a staff assistant from the State Department of Public Health: James W. Ellis, M.D., Cancer Consultant to the Department, serving with the subcommittee on *Medical and Related Personnel and Training;* Mr. Gordon R. Cumming, Chief, Bureau of Hospitals, *Medical Facilities and Supplies;* Ellis Sox, M.D., Chief, Division of Local Health Services, *Public Health Services;* Mr. Paul Shipley, Chief, Bureau of Records and Statistics, *Mortuary Services and Vital Records;* and Mrs. Ann W. Haynes, Chief, Bureau of Health Education, *Public Information and Education.*

The California Conference of Local Health Officers has also appointed a subcommittee on Civil Defense to integrate activities with the over-all plan of the State. The following health officers comprise this committee: Elmer Bingham, M.D., Santa Cruz County; S. F. Farnsworth, M.D., Oakland; J. C. Geiger, M.D., San Francisco; Roy O. Gilbert, M.D., Los Angeles County; J. D. Litwack, M.D., Long Beach; James Malcolm, M.D., Alameda County; L. S. McLean, M.D., Solano County, and W. Elwyn Turner, M.D., Santa Clara County.

Health Officer Changes

Byrl Rittenhouse, M.D., Redding, has been named health officer for Shasta County, succeeding Leland W. Bonar, M.D.

Victor Stallone, M.D., is the new health officer for the City of Albany, Alameda County, replacing Robert T. McMahon, M.D. Doctor Stallone's address is 1393 Solano Avenue, Albany.

Henry L. Fuller, M.D., has been appointed health officer for the City of Vacaville, succeeding Mr. O. E. Alley. Doctor Fuller's address is 547 Main Street, Vacaville.

State Civil Service Exams

Vector Control Specialist—An examination will be held November 14th for this position, with final date for filing applications October 24th. Salary range is $395-$481. Applicants must have educational qualifications equivalent to graduation from college with specialization in engineering, entomology, medical entomology, or parasitology, plus three years of experience in public health or sanitary engineering or in entomology. One year of experience must have been in the field of vector control. Additional qualifying experience may be substituted for four years of the required education on a year-for-year basis.

Hospital Field Representative—This examination, announced in the September 15th issue of *California's Health*, has been postponed from November 4th to November 25th. The closing date for applications has been extended to November 4th. Salary is $281 to $341.

Junior Chemist—This examination will be held December 2d, with final filing date November 10th. Salary range is $268 to $325. Applicants must have the equivalent to graduation from college with major work in chemistry. Chemical laboratory experience, including the making of technical chemical analyses, may be substituted for not more than four years of the required education on a year-for-year basis.

Sacramento Medical History Told in New Book

One hundred years of medical history in Sacramento is contained in a new book, "Memories, Men and Medicine," written by J. Roy Jones, M.D., and published by the Sacramento Society for Medical Improvement.

Largely a history of the Sacramento Society for Medical Improvement (the local medical society), the work weaves in interesting style the medical events through a century beginning with the gold rush era. The society was formed in 1868. Biographical sketches and portraits of the medical figures which have been the living part of Sacramento medical history are included.

Although the story has its setting in Sacramento, its contribution to the medical history of California goes beyond the locale. The wide influence of medical practice and thought in Sacramento is reflected in the book's pages, one section being devoted to the California State Board of Public Health, which had its beginning in Sacramento in 1870.

"Memories, Men and Medicine" is being distributed through Premier Publications, Ltd., 700 Ninth Street, Sacramento 14.

California Morbidity Reports

Selected Diseases—Civilian Cases

Total Cases for August and Total Cases for January Through August, 1950, 1949, 1948 and Five-year Median (1945-1949)

Reportable diseases	Current month: August				Cumulative: January through August			
	1950	1949	1948	5-yr. median, 1945-1949	1950	1949	1948	5-yr. median, 1945-1949
Amebiasis	34	26	36	18	241	217	372	128
Anthrax								
Botulism		2			3	2	3	3
Brucellosis (undulant fever)	16	14	7	14	73	70	113	174
Chancroid	24	47	28	39	181	380	277	340
Chickenpox	457	497	457	457	27,625	38,762	35,028	35,028
Cholera								
Coccidioidomycosis, disseminated	7	5	3	3	68	55	42	42
Conjunctivitis, acute infectious of newborn	1		2	2	5	6	13	16
Dengue								
Diarrhea of the newborn	1	4	2	4	59	32	91	91
Diphtheria	13	30	22	43	206	303	335	363
Encephalitis, infectious	81	6	12	28	150	31	37	79
Epilepsy	171	217	137	137	1,309	1,542	1,314	1,110
Food poisoning	101	20	10	20	1,148	381	292	327
German measles	158	183	96	107	1,977	17,273	3,016	10,386
Gonococcus infection	1,802	2,378	2,289	2,430	9,854	15,455	17,762	17,762
Granuloma inguinale	1	1	5	4	15	21	39	39
Hepatitis, infectious	31	20	9	9	257	393	58	136
Influenza, epidemic	22	16	19	19	375	667	14,550	735
Leprosy	1	1			4	7	10	9
Leptospirosis (Weil's disease)					3			
Lymphogranuloma venereum	11	18	11	11	90	165	160	160
Malaria	3	2	5	14	8	14	44	75
Measles	562	437	724	437	13,935	41,053	61,825	41,053
Meningitis, meningococcal	9	24	18	24	181	205	250	250
Mumps	775	1,191	936	936	29,390	33,133	25,444	25,444
Pertussis	498	598	215	598	5,584	2,723	2,870	2,870
Plague								
Pneumonia, infectious	104	105	88	105	1,379	1,228	1,285	1,345
Poliomyelitis, acute anterior	391	545	935	545	1,010	1,378	1,955	1,109
Psittacosis		3	1	1	6	8	11	7
Rabies, animal	14	15	17	15	71	132	213	213
Rabies, human						1		1
Relapsing fever	3	5		4	3	7	2	7
Rheumatic fever, acute	39	58	44	44	349	453	529	503
Rocky Mt. spotted fever					3	5	1	1
Salmonella infections*	40	19	20	19	293	262	68	68
Shigella infections (bacillary dysentery)	81	71	69	34	347	281	263	194
Smallpox								2
Streptococcal infections: Scarlet fever	108	94	109	151	3,379	2,493	2,590	3,704
Streptococcal sore throat (and "septic sore throat")	22	16	13	13	499	413	370	370
Syphilis	934	1,182	1,554	1,554	1,411	9,735	11,752	15,443
Tetanus	6	7	10	7	33	37	36	43
Trachoma	2	2	2	3	19	8	11	35
Trichinosis	2	6	4	3	14	16	31	15
Tuberculosis: Respiratory	902	821	672	695	4,964	5,813	5,502	5,502
Other forms	54	55	58	57	289	375	379	379
Tularemia	1	1			2	3	5	4
Typhoid fever	24	13	14	15	74	68	109	98
Typhus fever		1	3	3		3	14	20
Yellow fever								

* All types of Salmonella infections now reportable. Prior to January 1, 1950, only A, B and C types were reportable; hence five-year median not entirely comparable.

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